



# Planning for Delaware's Health Care Benchmark

A Review of the Evidence and Proposed Approach to Payment Reform

**Kara Odom Walker, MD, MPH, MSHS**

Cabinet Secretary

Delaware Department of Health and Social Services

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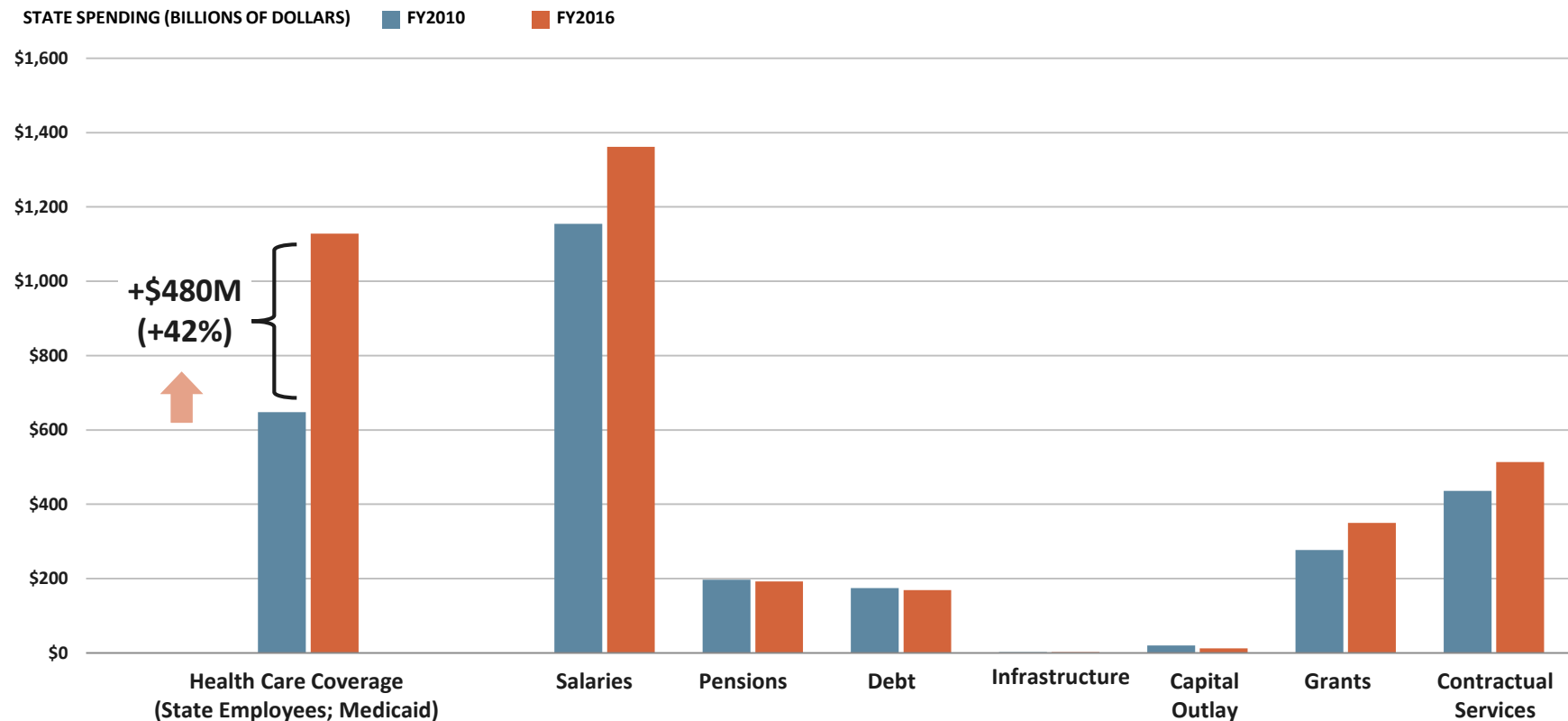
# OVERVIEW

- The Impact of Rising Health Care Costs in Delaware
- Proposed Solution
- Next Steps



# The Increasing Costs of Health Care Squeeze Out Other Public Spending Priorities

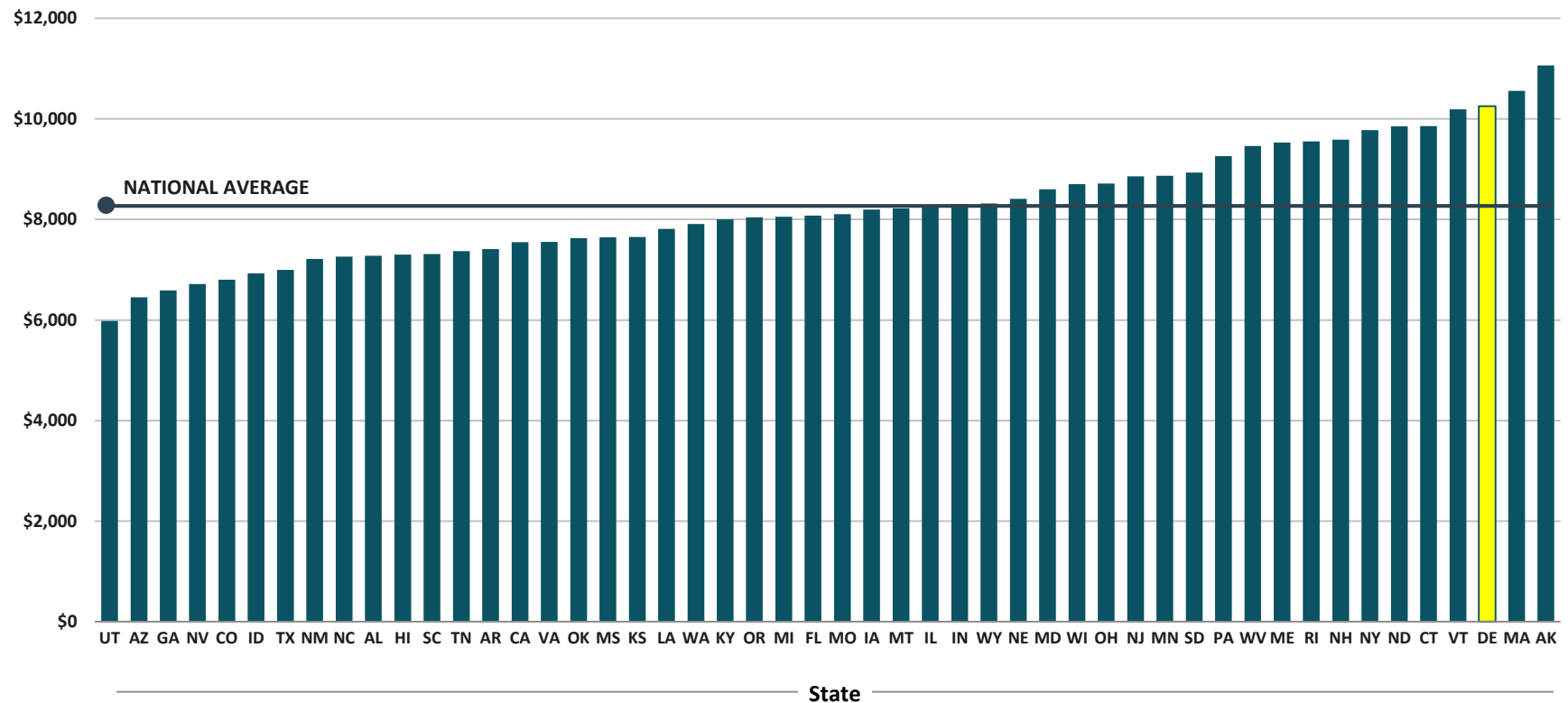
## DELAWARE STATE BUDGET, FY2010 VS. FY2016



SOURCE: Delaware Office of Management and Budget; DEFAC Expenditure Reports; general funds

# Delaware Spends More on Health Care than Most Other States

PER CAPITA PERSONAL HEALTHCARE EXPENDITURES, 2014

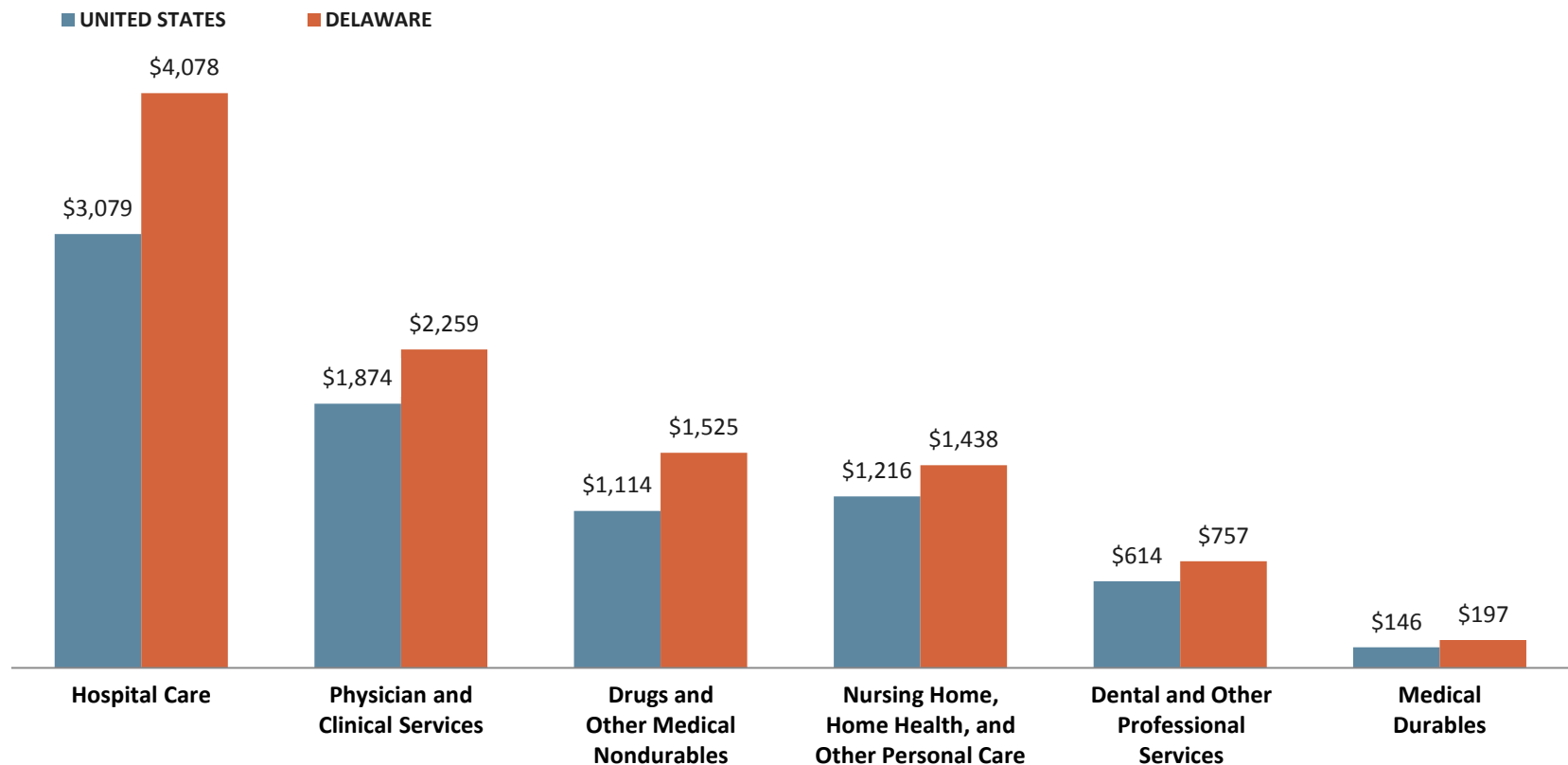


NOTE: District of Columbia is not included.

SOURCE: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2017.

# Per Person Spending in Delaware Is Higher than the National Average in Every Category of Service

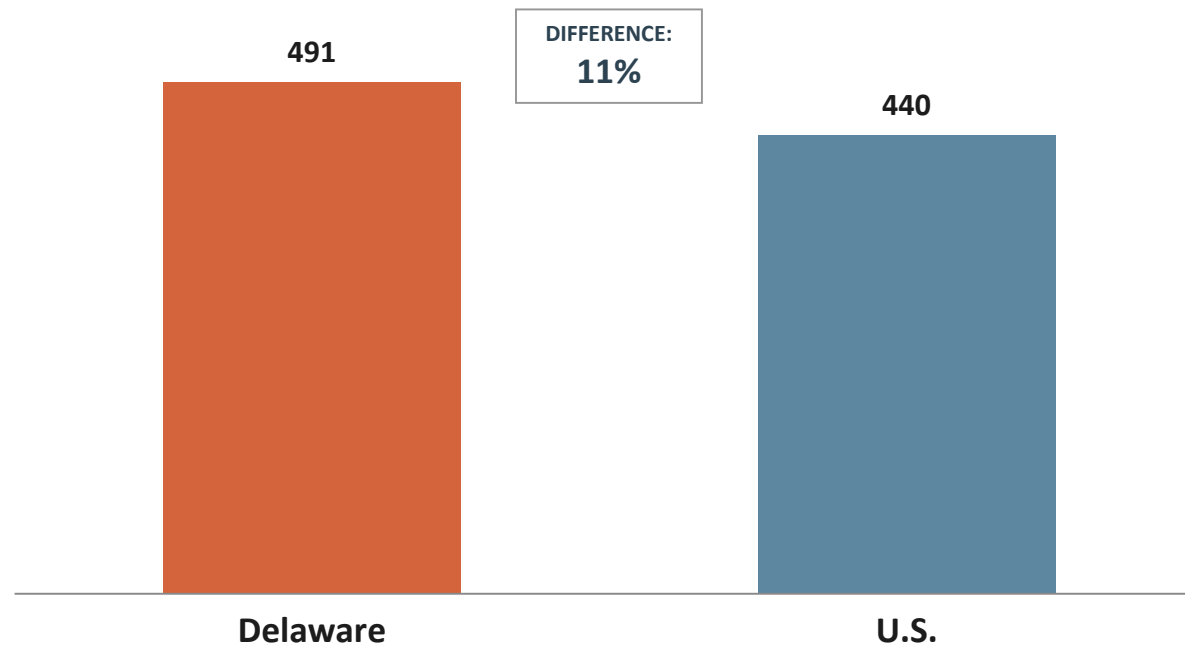
UNITED STATES AND DELAWARE PER CAPITA SPENDING BY SERVICE, 2014



SOURCE: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2017.

## UTILIZATION: Delaware Residents Use the Emergency Room Slightly More than U.S. Residents Overall

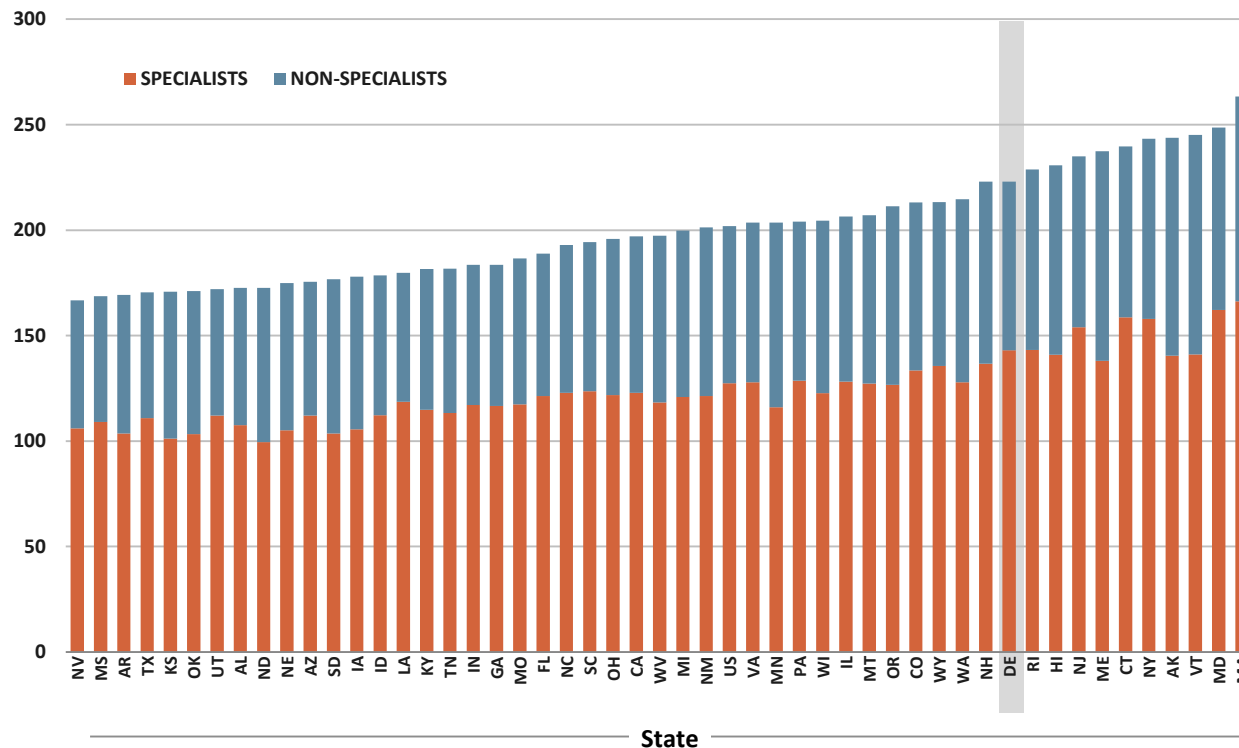
HOSPITAL EMERGENCY ROOM VISITS PER CAPITA IN DELAWARE AND IN THE U.S. OVERALL, 2009  
(ADMISSIONS PER 1,000 RESIDENTS)



SOURCES: Kaiser State Health Facts, with data from the American Hospital Association Annual Survey and U.S. Census.

## PROVIDER AND SERVICE MIX: Delaware is above Average for All States in Total Physicians and Specialists Per Capita

**SPECIALISTS AS A SHARE OF ALL PHYSICIANS BY STATE, 2006  
(PHYSICIANS PER 100,000)**



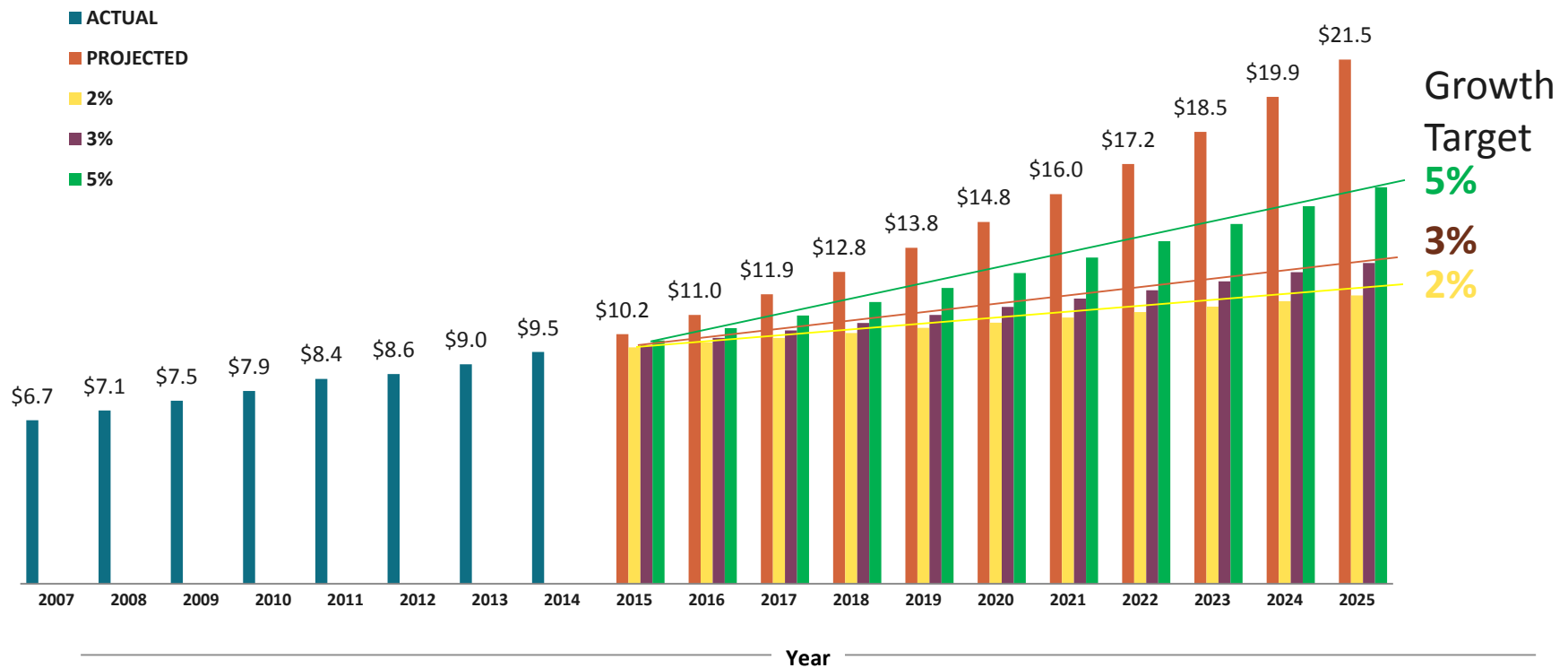
Delaware has more physicians per capita, and also more specialists per capita, than many other states. Research finds that regions with more total physicians tend to spend more on health care than other regions, and that states with a higher proportion of specialists also tend to spend more on health care.

NOTE: Physician counts are estimated from rates and population and are not exact. DC is excluded.

SOURCES: Physicians per capita data from Dartmouth Atlas. Evidence for relationship between more physicians and higher spending from Fisher, E.S., et. al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, Feb. 18, 2003.

# Total Health Spending Will Double from 2009 to 2020

ACTUAL AND PROJECTED DELAWARE TOTAL PERSONAL HEALTH CARE EXPENDITURES, 2007-2025  
(BILLIONS OF DOLLARS)



SOURCES: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2017;



## Current situation

- Health care costs consume ~30%<sup>1</sup> of DE's state budget, with significant current year deficit
- Total Delaware Medicaid spending was ~\$2.0B in Fiscal Year 2015, with ~\$1.2B coming from federal government<sup>3</sup>
- DE's average Medicaid Per Member Per Year (PMPYs) and growth trends are above the national average for most eligibility categories<sup>7,9</sup>
- DE State health purchasing currently accounts for nearly twice as many lives as many other states
- DE's individual marketplace received ~\$90M in federal support (subsidies and cost-sharing reductions)

## Sensitivity table of potential cost savings

	Savings from percent cost reduction		
	\$M		
Funding base	1%	3%	5%
State Medicaid funding (\$788M) <sup>7</sup>	8	23	39
State funding for State employees (\$762M) <sup>8</sup>	8	23	38
Total State health care spending (\$8B)	80	240	400

1 Health and Human Services accounted for 28.6% of expenditures in FY2015 (DE Expenditure Review Committee report); 2 Budget presentation FY 2017

3 MACPAC; 4 FY2013 (MACPAC); 5 2000-2011 for full benefit enrollees only (KFF)

6 ASPE reports monthly funding amount, which are annualized using a factor of 11.33 average member months (2015 MLR Report)

7 2015 (MACPAC); Medicaid spend breakdown by eligibility category in FY2011 is as follows: 14% aged, 32% individuals with disabilities, 35% adult, and 20% children (KFF)

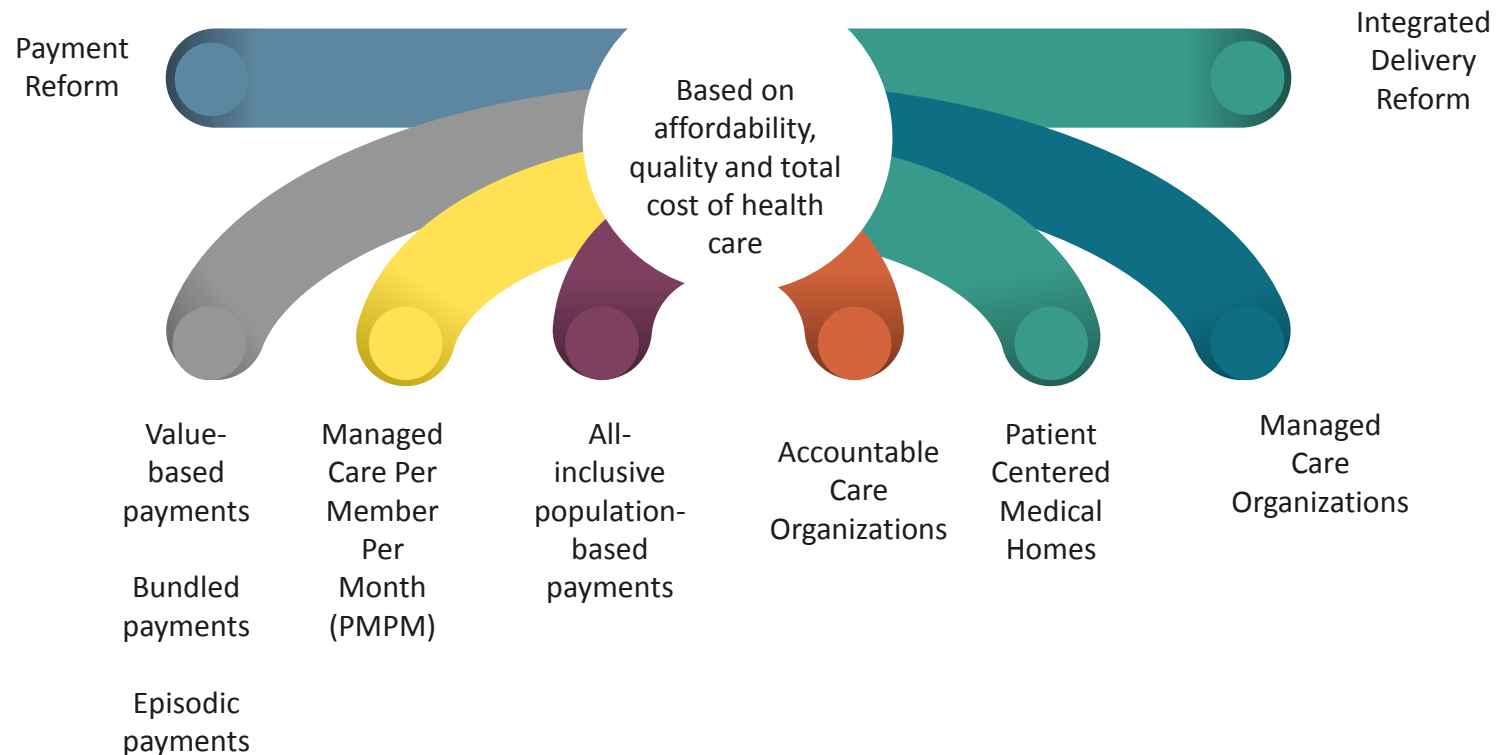
8 Estimated for FY2017 by multiplying average PEPY by # of enrolled employees (FY17 Q1 Quarterly Financial Report)

9 Growth trend for individuals with disabilities is below national average

# Examples of Payment Reform Models

	Description	Examples
<b>Total cost of care</b>	Accountability for the quality and total cost of care for a broad population of patients	<ul style="list-style-type: none"><li>Massachusetts</li><li>New York</li><li>Vermont</li><li>Medicare Shared Savings</li><li>NextGen Medicare ACO</li></ul>
<b>Bundled payments</b>	Accountability for the quality and cost of an episode of care for either a chronic condition, an acute exacerbation, or an acute procedure	<ul style="list-style-type: none"><li>Arkansas</li><li>Ohio</li><li>Tennessee</li><li>BPCI</li><li>CJR</li></ul>
<b>Special needs models</b>	Accountability for the quality and cost of supportive services for populations with severe mental illness, intellectual, developmental, or physical disabilities	<ul style="list-style-type: none"><li>Iowa</li><li>Massachusetts</li><li>Missouri</li><li>Tennessee</li></ul>

# Global Health Care Benchmark



# Moving Toward Innovative Strategies

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## Payment Strategies

- Cost growth goal
- Implement bundled payments for all payers and global budgets
- Finalize all-payer claims database and price transparency
- Consider reference pricing/cost monitoring

## Access issues

- Expand community-based strategies
- Combat addiction to prescription drugs and heroin
- Expand telehealth up and down state
- Decreased unplanned care

## Quality improvement

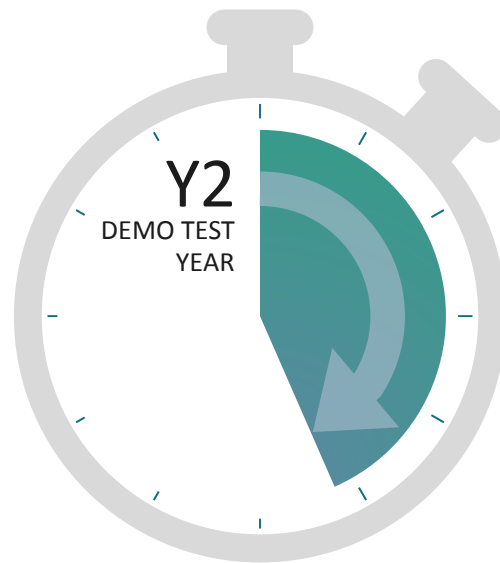
- Publish the common scorecard with cost and health outcomes
- Fully adopt value-based payment reform
- Integrated behavioral and primary care
- Improve long-term care
- Align the scope of practice needs with community needs (community health workers, nurse practitioners, behavioral health workers)

# IMPLEMENTATION PLAN

PHASED APPROACH TO GLOBAL HEALTH CARE BENCHMARK

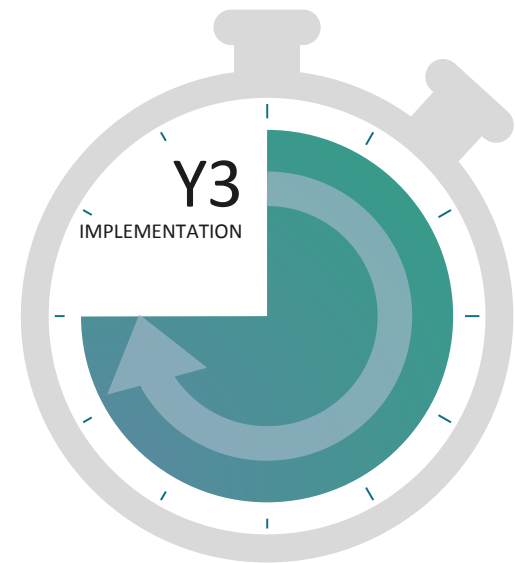


ESTABLISH LEGISLATION FOR  
HEALTH CARE SPENDING  
BENCHMARK



FOCUS ON PLANNING YEAR TO  
DETERMINE MODELS ACROSS  
MEDICAID, STATE  
EMPLOYEES/RETIREES AND  
FULLY INSURED

ESTABLISH THE AUTHORITY AND  
PERFORMANCE MANAGEMENT  
APPROACH



ALL ASPECTS OF THE  
IMPLEMENTATION ARE IN  
EFFECT

# Delaware's Progress on Voluntary Adoption of Value-Based Payment Reform

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- After receiving federal grant monies through the Centers for Medicare and Medicaid's State Innovation Model (SIM) project, Delaware has made a significant investment in transitioning to value-based payment models. Value-based payment models enable collaboration between providers and health systems in addition to allowing a greater focus on keeping people healthy through improving primary care. This is vastly different than the traditional Fee for Service model that aligns payment for services with volume, regardless of patient outcomes and whether the overall population of the state is getting healthier.
- The State has supported these changes from a policy perspective by setting the expectation for Medicaid Managed Care Organizations (MCOs) and State Employee/Retiree Third-Party administrators to offer and promote the adoption of value-based models.
- Currently, nearly 40% of primary care practices have participated in primary care practice transformation funded by the federal grant. Delaware recently became the first state in the country to achieve universal participation of our adult acute care hospitals in the Medicare Shared Savings Program. Some of these hospital systems as well as other physicians-led Accountable Care Organizations have recently begun to expand their participation into the Commercial segment as well. Overall, 30% of Delawareans are attributed to providers participating in value-based payment models.
- Despite this progress, many primary care providers in smaller practices have not yet chosen to participate in value-based models, and even for larger health systems the change to value-based payments can be expensive requiring retraining of providers, paying for services not reimbursed under the Fee for Service model, and making investments in health IT or other infrastructure to support value. In Delaware, we may already be seeing the limitations of a purely voluntary adoption model for payment reform.

## SUMMIT DATES

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- **September 7<sup>th</sup>: Establishing Benchmark/Signing of HJR7**
- **September 22<sup>nd</sup>: Provider/Hospital Leadership**
- **September 25<sup>th</sup>: Legal/Regulatory Issues**
  
- **October 18<sup>th</sup>: Data Analytics/Total Cost of Care Methodology**
- **November 2<sup>nd</sup>: Governance/Authority**
  
- **#myhealthde**
- **Facebook: DelawareDHSS**
- **Twitter: @Delaware\_DHSS**

SUBJECT TO CHANGE

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